

Wilson Interventional Clinic, P.A.

Authorization of Use and Disclosure of Protected Health Information

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Appointment Reminders

The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a sealed envelope, or, a brief, non-specific message may be left on your answering machine. Occasionally, we may also use "appointment cards" to remind you about upcoming appointments. If you don't approve of these methods and would like alternative reminder methods (i.e., email) please indicate those methods in the space provided (samples of appointment reminders are available upon request):

**How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Wilson Interventional Clinic, P.A.?
(Check all that apply.)**

Regular Mail

Home Telephone

Work Telephone

Appointment Cards

Email

Home Fax Machine

Other: _____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at **Wilson Interventional Clinic, P.A.**
(Check one.)

Yes

No

N/A

If "NO," how else may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

Other Uses and Disclosures

Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:

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Persons Authorized to Receive Information

Health information **Wilson Interventional Clinic, P.A.** collects or receives about you may be disclosed to the following persons:

Name of person / relation / organization

Name of person / relation / organization

Use and Disclosure of Information

I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at **Wilson Interventional Clinic, P.A.**

I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify):

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Matt B. Wilson, M.D. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure

The person or organization to which health information is sent, may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient